CHAPTER VI: HOME HEALTH PPS PAYMENT CALCULATIONS

OBJECTIVES

The objective of this chapter is to provide participants with an understanding of the Home Health Prospective Payment system payment provisions. At the end of this session, participants will obtain an understanding of:

- The computation of the base 60-day episode payments for the 80 home health resource groups as represented by 640 HIPPS codes.
- The computation of adjustments to the 60-day episode payment for low utilization or outlier situations.
- The prorating of payments for significant changes in the patient condition, beneficiary elected transfers or discharge and readmission to the same HHA.
- The effect of HH PPS on the PS&R and cost reporting.

BACKGROUND

Episode of Care Payment

- **60-day Period**
- **Adjusted for Health Condition and Care Needs**
- **Adjusted for Wage Variances**
- **No Limit to Number of Episodes**

Payment for services under the home health PPS system is calculated based on a predetermined base payment. The base payment will be adjusted for the health condition and care needs of the beneficiary (case-mix adjustment). Payments will also be adjusted to reflect the geographic differences in wages for HHAs across the country (wage index adjustment).

HH PPS will provide HHAs with payments for each 60-day episode of care for each beneficiary serviced by the HHA. If a beneficiary is still eligible for care after the end of an episode, a second episode can begin. There are no limits to the number of episodes an eligible beneficiary can receive.

Split Payment Approach

- **Initial Episode 60/40 Split**
- **Subsequent Episodes 50/50 Split**

The unit of payment under HH PPS is a 60-day episode of care. HHAs will receive 60 percent of the estimated base payment for the first full 60-day episode as soon as the fiscal intermediary receives the initial claim. The estimated payment will be based on the patient's condition and care needs. The agency will receive the remaining 40 percent of the payment at the close of the 60-day episode unless there is an applicable adjustment to that amount. All subsequent episodes will be paid at a 50/50-split percentage payment.

The split percentage payment approach was developed to provide reasonable and balanced cash flow to participating HHAs.

Payment calculations are performed by the HH PPS Pricer software driver, which interacts with existing standard system software (FISS and APASS). Pricer computes calculations to the ninth decimal place. However, most of the examples in this chapter are rounded to two decimal places for easy comprehension.

CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNT

Calculation of National 60-Day Episode Amount

- **FY 1997 Cost Report Data Used to Compute Mean Cost per-Visits**
- **97 and 98 Claims Data used to Compute Mean Utilization Amounts**
- **Updated For Inflation**

Resulted in Non-Standardized Prospective Payment Amount

HCFA used audited cost report data for cost reports that ended in fiscal year 1997, to compute national mean cost per visits, for each of the six disciplines (skilled nursing, physical therapy, occupational therapy, speech-language pathology services, medical social services, and home health aide services).

The national mean cost per visit amounts were then multiplied by the national mean utilization for each of the six disciplines in a 60-day episode to arrive at a national cost per episode amount. The national mean utilization amounts were derived utilizing data from the 1997 and 1998 National Claims History File.

The cost per episode amount was updated for inflation and additional amounts were added for the following:

- Non-routine medical supplies paid on a reasonable-cost basis under a home health plan of care
- Non-routine medical supplies that could have been unbundled to Part B that will be included under the PPS rate
- Therapy services that could have been unbundled to Part B that will be included under the PPS rate
- An OASIS adjustment to pay HHAs for estimated ongoing OASIS assessment reporting costs
- A one-time implementation adjustment to pay HHAs for estimated costs associated with implementing revisions to the OASIS

Non-Standardized Prospective Payment Amount Adjusted for:

- **Case-mix**
- **Budget Neutrality**
- **Outlier**

2001 Standard Prospective Payment Rate $2,115.30

The resulting nonstandardized average prospective payment amount was further adjusted for the following:

- Standardized for case-mix and wage index
- Adjusted for budget-neutrality
- Divided by 1.05 to provide for outlier payments

The final standardized and budget neutral prospective payment amount per 60-day episode for FY 2001 is $2,115.30.

ADJUSTMENTS TO STANDARDIZED PROSPECTIVE PAYMENT RATE

Sample Payment Computation Data

To assist in understanding the payment concepts of the HH PPS system, we will work through the computations for an HHA with the following information:

- Services provided to beneficiary in State College, PA.
- OASIS has determined that the beneficiary is in HHRG C2F2S2 (HIPPS code HCGL1)
- The Standardized Prospective Payment Rate for FY 2001 has been defined as $2,115.30.
- The beneficiary receives the first billable service on October 1, 2000.

Case-Mix Adjustment

Case-mix Adjustment

Listing of HHRG, HIPPS, and Weights

A listing of the 80 HHRG Groupings and the appropriate case-mix weight has been published in the final rule (table 9). A listing of the HHRGs, HIPPS codes and case-mix weights is also included in the appendix (section 1) of this manual.

In our example, OASIS has determined that the beneficiary is in HHRG C2F2S2. Using the listing included in section 1 of the appendix, we can identify a HIPPS code of HCGL1 and a case mix weight of 1.9532. The case-mix adjusted prospective rate would be computed as follows:

Computation of Case-Mix Adjusted Prospective Payment Amount		
1	Weight for HCGL1	1.9532
2	Standardized Prospective Payment Rate	$2,115.30
3	Calculated case-mix adjusted prospective payment rate (line 1 x line 2)	$ 4,131.60

Wage Index

- **Hospital Wage index**
- **Pre-Reclassification**
- **Pre-Floor**
- **Labor Portion 77.668%**

Wage Index Adjustment

Under HH PPS, the labor portion of the 60-day episode payment will be adjusted by the appropriate wage index for the geographic area in which the beneficiary received home health services. The hospital wage index in effect for the federal fiscal year will be used to determine payments for home health services. The wage index values, pre-floor and pre-reclassification, will be published in the *Federal Register.*

Based on an analysis of the components of the HH market basket, HCFA has determined that 77.668% of the standardized prospective payment rate represents labor costs.

Services for our example were provided to a beneficiary located in State College, PA. State

College is located in MSA 8050, with a wage index of .9139.

The case-mix adjusted prospective rate will be adjusted for the wage index as follows:

Wage Index Adjustment to Case-Mix Adjusted Prospective Payment Amount		
1	Case Mix Adjusted Prospective Payment Rate (from above)	$ 4,131.60
2	Labor Percentage of Prospective Payment Rate	0.77668
3	Labor Portion of Prospective Payment Rate (line 1 x line 2)	$ 3,208.93
4	Wage Index Factor	.9139
5	Wage Adjusted Labor Portion of Prospective Payment Rate (line 3 x line 4)	$ 2,932.64
6	Non-Labor Portion of Prospective Payment Rate (line 1 less line 3)	$ 922.67
7	Total Adjusted Prospective Payment Rate (line 5 + line 6)	$ 3,855.31

REQUEST FOR ANTICIPATED PAYMENT

RAP

- **Initial Episode 60/40 Split**
- **Subsequent Episodes 50/50 Split**

HHAs will receive 60 percent of the estimated base payment for the first full 60-day episode as soon as the fiscal intermediary receives the request for anticipated payment (RAP). All subsequent RAPs for the beneficiary will be paid at 50%. The agency will receive the remaining 40 percent (or 50 percent) of the payment at the close of the 60-day episode unless there is an applicable adjustment to that amount. Note: RAPs are not equivalent to claims in terms of Medicare stature and therefore are not subject to either the payment floor or interest payments (in cases where a clean RAP is held up in claims processing).

Using our example (see sample claim #I in this chapter), following is a calculation of the RAP and a calculation of the additional final payment for the episode. For this calculation, it is assumed that the final payment will not be subject to any payment

adjustments that will be discussed later in this chapter.

Calculation of Initial (RAP) and Final Prospective Payment Amount		
1	Total Adjusted Prospective Payment Rate (from above)	$ 3,855.31
2	Initial (RAP) Percentage	60%
3	Initial (RAP) Payment (line 1 x line 2)	$ 2,313.19
4	Final HH PPS Payment (Line 1 – Line 3)	$ 1,542.12

FINAL PAYMENT ADJUSTMENTS

Low-Utilization Payment Adjustments

Low Utilization Payments

- **Four of Fewer Visits**
- **Per-Visit Methodology**

The final regulations provide for payments for low-utilization episodes under HH PPS. Low-utilization episodes have been defined as those with 4 or fewer home health visits in the 60-day episode. Low utilization adjustments (LUPAs) would reduce the HH PPS payment for services during the 60-day episode. If the LUPA payment is less than the RAP payment made with the initial claim, the difference will be recovered on subsequent billings.

Payments for low-utilization episodes will be made on a per-visit basis using cost per-visit rates by discipline. Cost per-visit rates are published in the final rule (table 6). Following is a listing of the cost per-visit rates:

Home Health Discipline Type	HH Payment Rate
Home Health Aide Services	$43.37
Medical Social Services	$153.55
Occupational Therapy Services	$105.44
Physical Therapy Services	$104.74
Skilled Nursing Services	$95.79
Speech Pathology Services	$113.81

Low-utilization payments will be adjusted for wage index variances, but will not be adjusted for case-mix.

Using our example (see sample claim #2), let's assume that the HHA submitted a final bill that reflected only 2 home health visits over the 60-day episode of care (one skilled nursing and one home health aide visit). The LUPA payment would be calculated as follows:

Calculation of LUPA Payment		Skilled Nursing Visit	Home Health Aide Visit
1	Per-Visit Payment Amount	$95.79	$43.37
2	Labor Percentage	.77668	.77668
3	Labor Portion of Payment Rate (line 1 x line 2)	$74.40	$33.68
4	Wage Index	.9139	.9139
5	Wage Adjusted Labor Portion of Payment Rate (line 3 x line 4)	$67.99	$30.78
6	Non- Labor Portion of Payment Rate (line 1 – line 3)	$21.39	$9.69
7	Adjusted LUPA Payments (line 5 + line 6)	$89.38	$40.47
8	Total LUPA Payment		$129.85

The total adjusted payments for this example episode will be $129.85. As the provider received a RAP payment of $2,313.19, the excess payment of $2,183.34, will have to be recovered in future payments to the HHA.

NO RAP LUPA

In some LUPA situations the HHA will not submit a RAP. If it determines before submitting the RAP that the beneficiary will receive (or has received) 4 or fewer visits during an episode, the HHA may submit a Final Claim without submitting a RAP.

Partial Episode Payment

Accounts for Key Events in Patient Care

- **Beneficiary Elected Transfer**
- **Discharge and Return to Same HHA**

Partial Episode Payments

Partial episode payment adjustments (PEP adjustments) will be used to adjust HH PPS episode payments in some cases where a discharge has occurred. Discharges resulting in a PEP adjustment include:

- a beneficiary elected transfer,
- a discharge and return to the same HHA within the 60-day episode period, or

The PEP adjustment is based on the span of days including the start-of-care date/first billable service date through and including the last billable service date under the original plan of care before the intervening event. The PEP adjustment is calculated by using the span of days under the original plan of care, as a proportion of 60. The proportion is multiplied by the original case-mix and wage-adjusted 60-day episode payment.

Beneficiary Elected Transfer

- **Initial Episode Closed with PEP**
- **New Episode at Second HHA**

Common Ownership

Adjustment for Beneficiaries who Change HHAs

In situations where the beneficiary elects to transfer to a different HHA, the initial HH episode payment will be closed out with a PEP adjustment and a new 60-day episode period will start for the new beneficiary elected HHA.

Using our example (see sample claim #3), let's assume that the beneficiary elects to transfer to a non-related HHA. The beneficiary's last billable service from the initial HHA was on October 20, 2000. A PEP will be calculated for the initial HHA as follows:

PEP Adjustment for Initial HHA		
1	Total Adjusted Prospective Payment Rate (from above)	$ 3,855.31
2	Span of Days of Care Provided by Initial HHA (Oct. 1, through Oct. 20, 20 days)	20
3	Span of Days as a Proportion of 60 (line 2/60)	0.333333
4	Initial HH PEP Payment (Line 1 x Line 3)	$ 1,285.10

The total adjusted payments for the initial HHA will be $1,285.10. As the provider received a RAP payment of $2,313.19, the excess payment of $1,028.09 will have to be recovered in future payments to the HHA.

A new 60-day episode period will begin at the beneficiary elected HHA.

This treatment will only be applied where the beneficiary elects a transfer between HHAs without common ownership. PEP adjustments will not apply if the transfer is between organizations of common ownership. The common ownership exception does not apply if the beneficiary moved out of the MSA or non-MSA during the 60-day episode before the transfer to the new HHA.

Discharge and Return to Same HHA

- **Initial Episode Closed with PEP**
- **New Episode for Re-Admission**
- **No Change in Condition**

Adjustment for Discharge and Readmission to Same HHA

A PEP adjustment will also be computed where a beneficiary is discharged and subsequently returns to the same HHA within the 60-day period. A PEP adjustment will only be recognized when a beneficiary reached the treatment goals in the original plan of care. The original plan of care must be terminated with no anticipated need for additional home health services for the balance of the 60-day period. The discharge cannot be the result of a significant change in condition.

The initial HHA episode payment will be closed out with a PEP adjustment and a new 60-day episode

period will start beginning with the date of the first billable service after re-admission to the HHA.

Using our example (see sample claim #4), let's assume that the beneficiary is discharged because treatment goals in the original plan of care were met. The beneficiary's last billable service from the initial HHA was on Nov. 10, 2000. The beneficiary is re-admitted to the HHA with the first billable services delivered on Nov. 25, 2000. A PEP will be calculated for the initial episode as follows:

PEP Adjustment for Initial Episode		
1	Total Adjusted Prospective Payment Rate (from above)	$ 3,855.31
2	Span of Days of Care Provided by Initial HHA (Oct. 1, through Nov. 10, 41 days)	41
3	Span of Days as a Proportion of 60 (line 2/60)	0.683333
4	Initial Episode PEP Payment (Line 1 x Line 3)	$ 2,634.46

The total adjusted payments for the initial HHA will be $2,634.46. As the provider received a RAP payment of $2,313.19, an additional final payment of $321.27 will be made to the HHA.

A new 60-day episode period will begin at the HHA beginning on Nov. 25, 2000.

Note: The above example assumes the HHA had not already submitted the claim for the episode. If the claim had been submitted not reflecting the PEP adjustment, this claim would be automatically adjusted by the standard system and CWF to reflect the PEP adjustment, and recoupment would be made against future payments if warranted.

Significant Change in Condition

- **Multiple Part Calculation**
- **PEP Adjustments for Periods Before/After SCIC**

Adjustment for Significant Change in Condition

Another event that could trigger a change in payment level over the course of a 60-day episode of care is a significant change in condition (SCIC). A SCIC adjustment reflects a proportional payment adjustment for the time both before and after the patient experienced a significant change in condition during the episode. A SCIC adjustment occurs when a beneficiary experiences a significant change in condition during a 60-day episode that was not envisioned in the original plan of care. In order to receive a new case-mix assignment for purposes of SCIC payment during the 60-day episode, the HHA must complete an OASIS assessment and obtain the necessary physician change orders reflecting the significant change in treatment approach in the patient's plan of care. When the new assessment is input into HAVEN software, the Grouper module in that software will output a new HIPPS code reflecting the change in condition for payment purposes

The SCIC adjustment could be calculated in multiple parts. The first part of the SCIC adjustment reflects the adjustment to the level of payment before the significant change in the patient's condition during the 60-day episode. The second part of the SCIC adjustment reflects the adjustment to the level of payment after the significant change in condition occurs during the 60-day episode. There is no limit on the number of SCIC adjustments that may be made in a given episode, though many such adjustments in a single 60-day span should prove rare.

Using our example (see sample claim #5), let's assume that the beneficiary experiences a significant change in condition on Oct. 20, 2000. The beneficiary's last billable service before the SCIC was on Oct. 20, 2000. The beneficiary receives the first billable service under the new plan of care on Oct. 25, 2000. The new HIPPS Code is HCHM1, with a case-mix weight of 2.2429.

The first part of the SCIC adjustment is determined by taking the span of days before the patient's significant

change in condition as a proportion of 60 multiplied by the original episode payment amount.

SCIC Adjustment – First Part		
1	Initial Episode Prospective Payment Rate (from above)	$ 3,855.31
2	Span of Days of Care before SCIC (Oct. 1, through Oct. 20, 20 days)	20
3	Span of Days as a Proportion of 60 (line 2/60)	0.333333
4	Initial Episode SCIC Payment (Line 1 x Line 3)	$ 1,285.10

The second part of the SCIC adjustment is determined by taking the span of days (first billable service date through the last billable service date) after the patient experiences the SCIC, through the balance of the 60-day episode as a proportion of 60 multiplied by the new episode payment.

Computation of Case-Mix Adjusted Prospective Payment Amount – After SCIC		
1	Case Mix index for HCHM1	2.2429
2	Standardized Prospective Payment Rate	$ 2,115.30
3	Calculated Case-Mix Adjusted Prospective Payment Rate (line 1 x line 2)	$ 4,744.41

Wage Index Adjustment to Case-Mix Adjusted Prospective Payment Amount – After SCIC		
1	Case Mix Adjusted Prospective Payment Rate (from above)	$ 4,744.41
2	Labor Percentage of Prospective Payment Rate	0.77668
3	Labor Portion of Prospective Payment Rate (line 1 x line 2)	$ 3,684.89
4	Wage Index Factor (table 4B)	.9139
5	Wage Adjusted Labor Portion of Prospective Payment Rate (line 3 x line 4)	$ 3,367.62
6	Non-Labor Portion of Prospective Payment Rate (line 1 less line 3)	$ 1,059.52
7	Total Adjusted Prospective Payment Rate (line 5 + line 6)	$ 4,427.14

SCIC Adjustment – Second Part		
1	Initial Episode Prospective Payment Rate (from above)	$ 4,427.14
2	Span of Days of Care before SCIC (Oct. 25, through Nov. 29, 36 days)	36
3	Span of Days as a Proportion of 60 (line 2/60)	0.600000
4	Second SCIC Payment (Line 1 x Line 3)	$ 2,656.28

The total payments for the HHA are summarized below:

1	SCIC Adjustment First Part	$1,285.10
2	SCIC Adjustment Second Part	$2,656.28
3	Subtotal	$3,941.38
	Less: RAP Payment	$2,313.19
4	Additional Payment To HHA	$1,628.19

CLAIMS EXAMPLES

Sample Claim #1 -Processed RAP

Your Agency Name
Address
City, State, Zip

4 TYPE OF BILL: 322

6 STATEMENT COVERS PERIOD FROM: 10012000 THROUGH: 10012000

12 PATIENT NAME: Doe Jane M

13 PATIENT ADDRESS: 123 Main Street State College, PA 16803

14 BIRTH DATE: 03151920

15 SEX: F

17 ADMISSION DATE: 10012000

20 SRC: 1

22 STAT: 30

39 VALUE CODES: a 61 — 8050.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0023	HH Services	HCGL1	10012000		2313.19		
0001					2313.19		

50 PAYER: A Medicare

51 PROVIDER NO.: 167999

52 REL INFO: Y

58 INSURED'S NAME: Doe, Jane M

60 CERT.-SSN-HIC.-ID NO.: 123456789A

63 TREATMENT AUTHORIZATION CODES: A 10012000930200001

67 PRIN DIAG CD: 1629

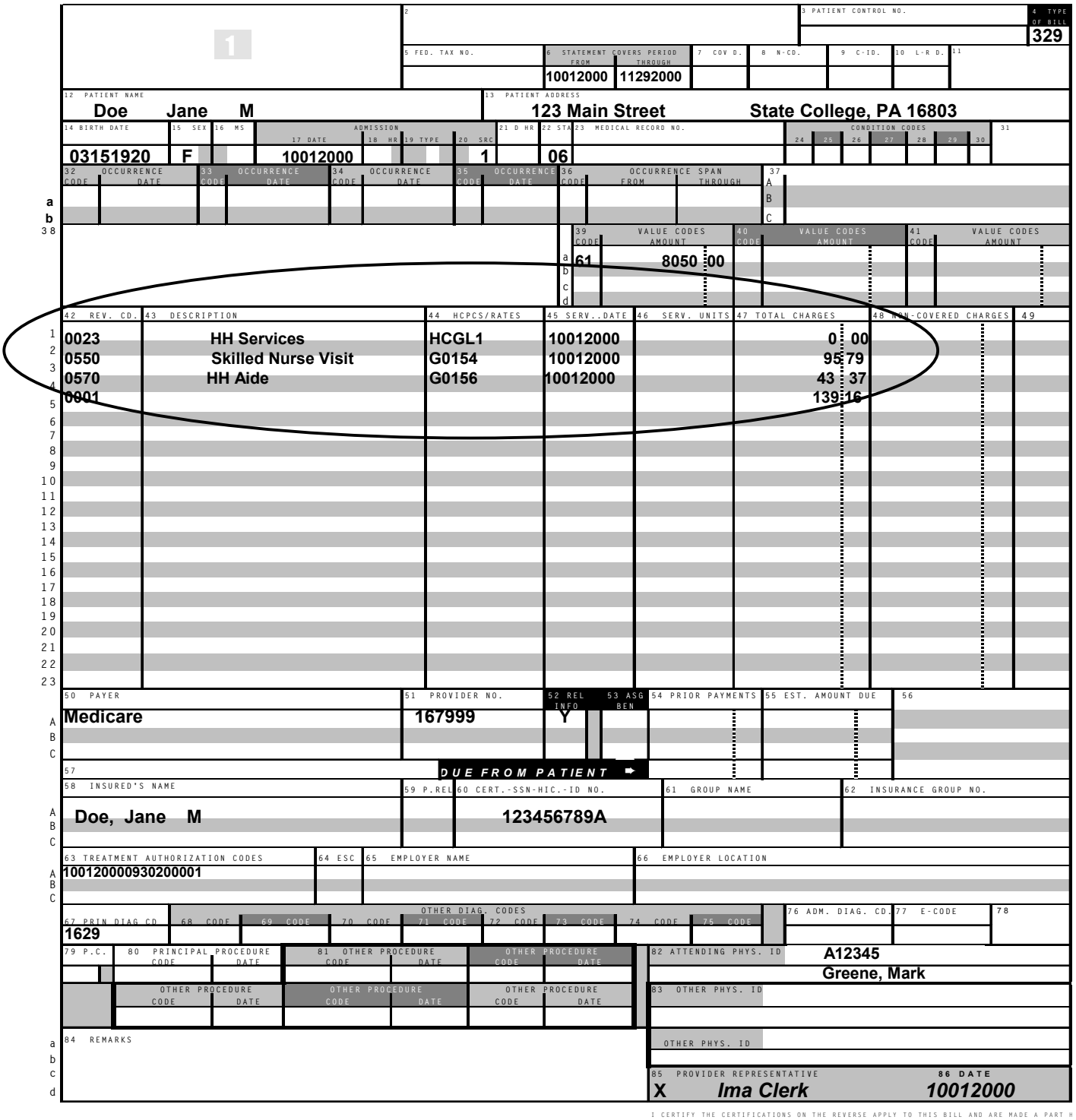
82 ATTENDING PHYS. ID: A12345 Greene, Mark

85 PROVIDER REPRESENTATIVE: X *Ima Clerk*

86 DATE: *10012000*

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Sample Claim #2 -Processed Final Claim (LUPA)



1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
			329

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-CD.	9 C-ID.	10 L-R D.	11
	10012000	11292000					

12 PATIENT NAME	13 PATIENT ADDRESS
Doe Jane M	123 Main Street State College, PA 16803

14 BIRTH DATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STA	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
03151920	F		10012000			1		06			

32 OCCURRENCE CODE	DATE	33 CODE	DATE	34 CODE	DATE	35 CODE	DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a											A
b											B
38											C

39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a 61	8050 00				
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV..DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0023	HH Services	HCGL1	10012000		0 00		
2	0550	Skilled Nurse Visit	G0154	10012000		95 79		
3	0570	HH Aide	G0156	10012000		43 37		
4	0001					139 16		
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23								

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicare	167999	Y				
B						
C						

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, Jane M		123456789A		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A 100120000930200001			
B			
C			

67 PRIN DIAG CD	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1629											

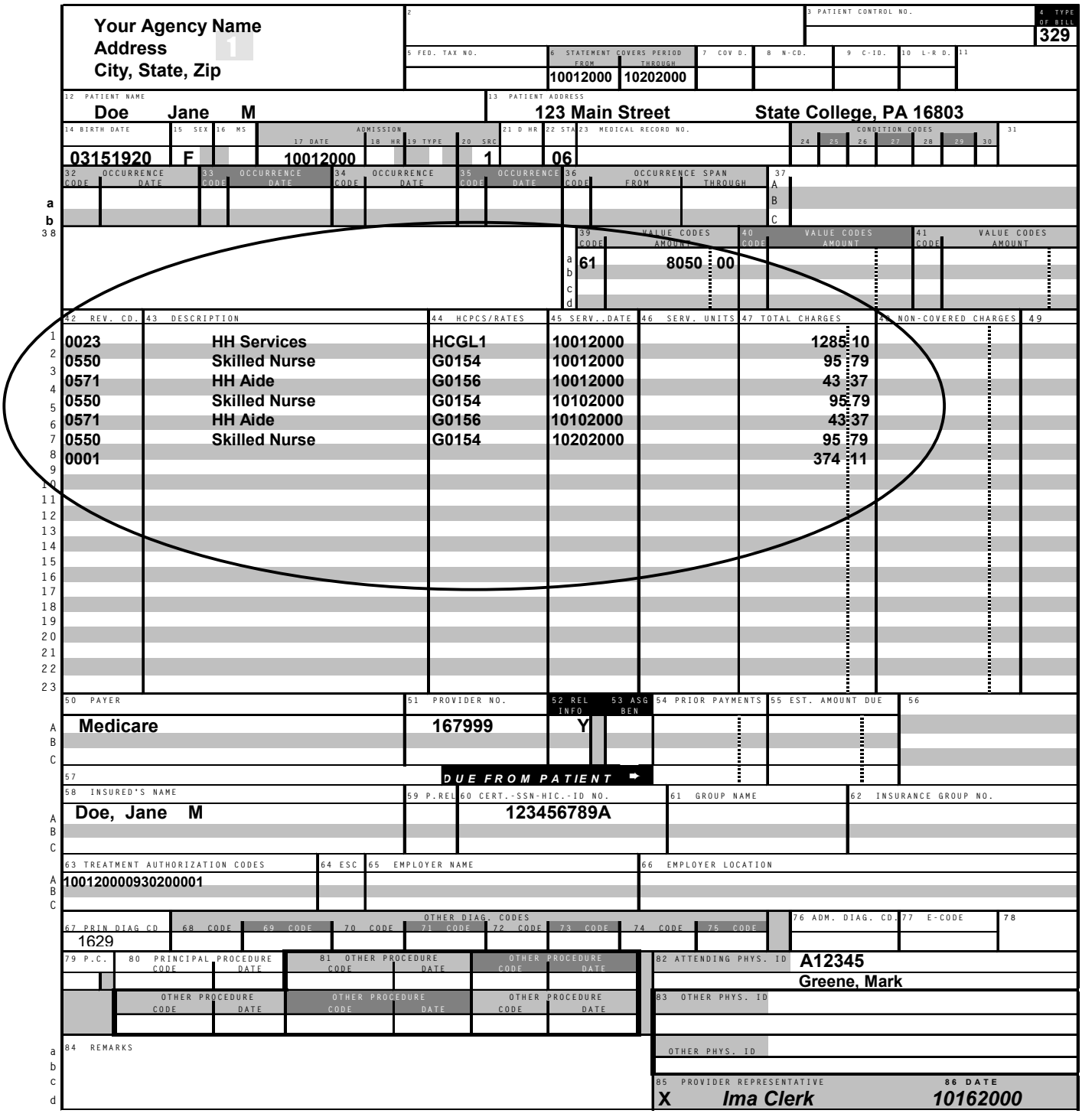
79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
							A12345 Greene, Mark
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

a 84 REMARKS	OTHER PHYS. ID
b	
c	85 PROVIDER REPRESENTATIVE 86 DATE
d	X Ima Clerk 10012000

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Sample Claims # 3 -Processed Final Claim

(PEP Adjustment b/c of Beneficiary Transfer; this claim submitted by agency beneficiary is transferring from



Your Agency Name
Address
City, State, Zip

4 TYPE OF BILL	6 STATEMENT COVERS PERIOD FROM	THROUGH
329	10012000	10202000

12 PATIENT NAME: Doe Jane M
13 PATIENT ADDRESS: 123 Main Street State College, PA 16803

14 BIRTH DATE	15 SEX	17 ADMISSION DATE	20 SRC	22 STA
03151920	F	10012000	1	06

39 VALUE CODES AMOUNT: a 61 8050 00

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV..DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	0023	HH Services	HCGL1	10012000		1285 10	
2	0550	Skilled Nurse	G0154	10012000		95 79	
3	0571	HH Aide	G0156	10012000		43 37	
4	0550	Skilled Nurse	G0154	10102000		95 79	
5	0571	HH Aide	G0156	10102000		43 37	
6	0550	Skilled Nurse	G0154	10202000		95 79	
7	0001					374 11	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN
A Medicare	167999	Y	

DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.
A Doe, Jane M		123456789A

63 TREATMENT AUTHORIZATION CODES: A 100120000930200001

67 PRIN DIAG CD: 1629

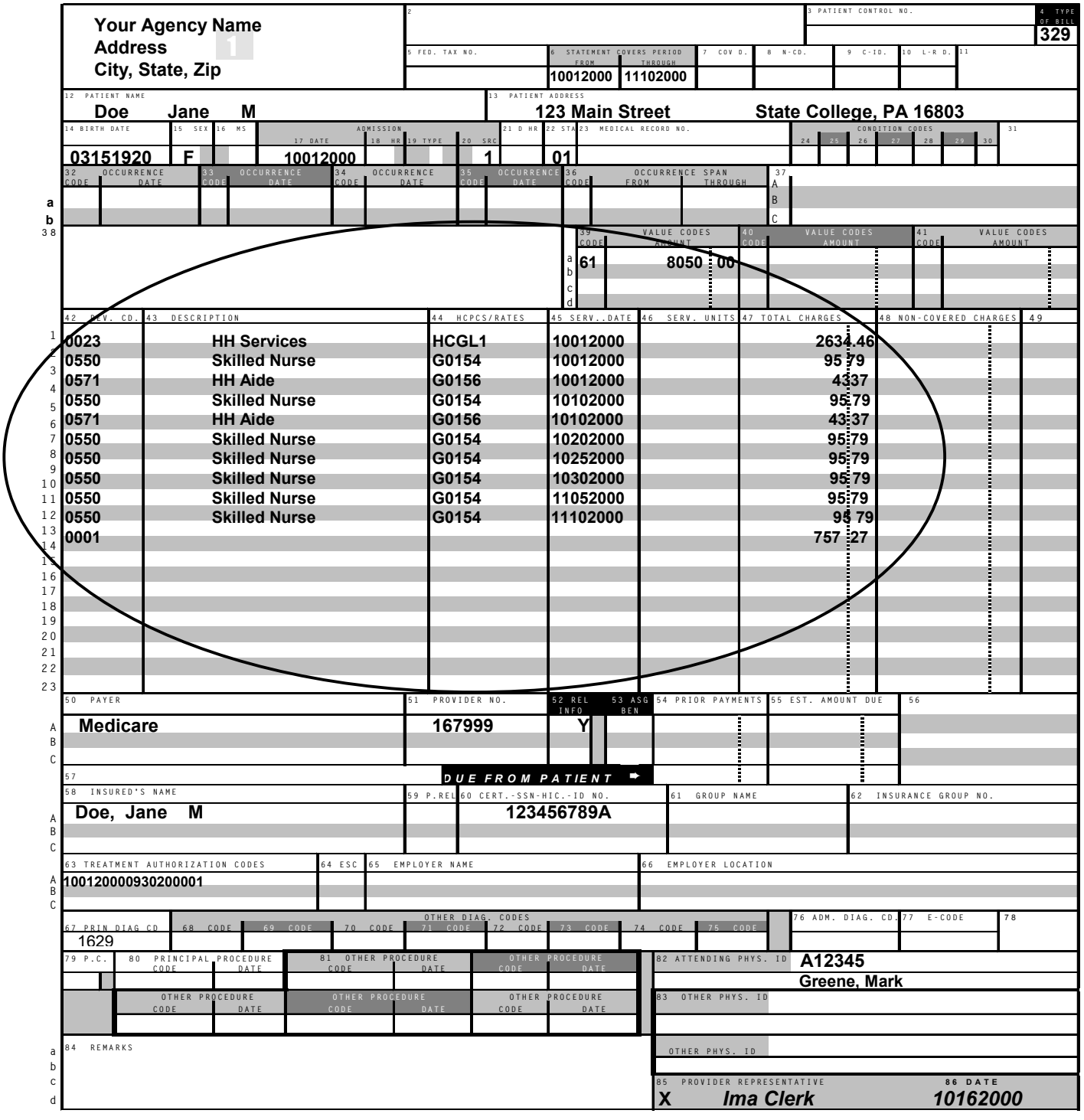
82 ATTENDING PHYS. ID: A12345 Greene, Mark

85 PROVIDER REPRESENTATIVE: X *Ima Clerk* 86 DATE: *10162000*

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Sample Claim # 4 -Processed Final Claim (PEP Adjustment)

(PEP Adjustment b/c of Beneficiary Discharge; this claim submitted by agency beneficiary is discharged from)



1	Your Agency Name Address City, State, Zip
4 TYPE OF BILL	329
6 STATEMENT COVERS PERIOD FROM	10012000
THROUGH	11102000
12 PATIENT NAME	Doe Jane M
13 PATIENT ADDRESS	123 Main Street State College, PA 16803
14 BIRTH DATE	03151920
15 SEX	F
17 ADMISSION DATE	10012000
20 SRC	1
22 STA	01
39 VALUE CODES AMOUNT a	61 8050 00

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV..DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	0023	HH Services	HCGL1	10012000		2634.46	
2	0550	Skilled Nurse	G0154	10012000		95 79	
3	0571	HH Aide	G0156	10012000		4337	
4	0550	Skilled Nurse	G0154	10102000		95.79	
5	0571	HH Aide	G0156	10102000		43.37	
6	0550	Skilled Nurse	G0154	10202000		95.79	
7	0550	Skilled Nurse	G0154	10252000		95.79	
8	0550	Skilled Nurse	G0154	10302000		95.79	
9	0550	Skilled Nurse	G0154	11052000		95.79	
10	0550	Skilled Nurse	G0154	11102000		95 79	
11	0001					757 27	
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicare	167999	Y				
57	DUE FROM PATIENT ➡					
58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.		
A Doe, Jane M		123456789A				
63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION			
A 100120000930200001						

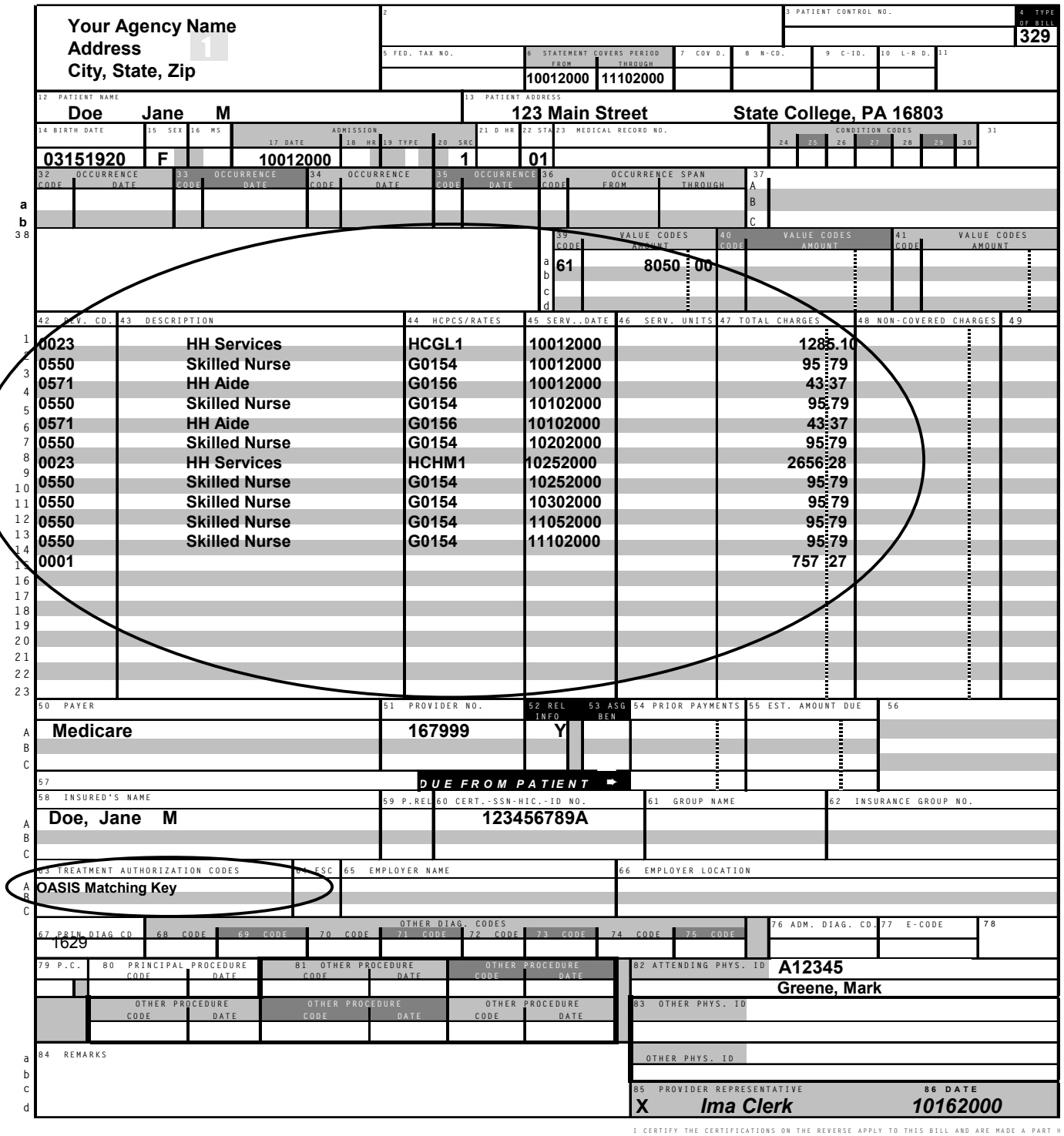
67 PRIN DIAG CD	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1629											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	A12345
								Greene, Mark
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	

a 84 REMARKS		OTHER PHYS. ID	
		85 PROVIDER REPRESENTATIVE	86 DATE
		X *Ima Clerk*	*10162000*

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Sample Claim #5 - Processed Final Claim (SCIC Adjustment)



Your Agency Name
Address
City, State, Zip

4 TYPE OF BILL: 329
6 STATEMENT COVERS PERIOD: FROM 10012000 THROUGH 11102000

12 PATIENT NAME: Doe Jane M
13 PATIENT ADDRESS: 123 Main Street State College, PA 16803
14 BIRTH DATE: 03151920
15 SEX: F
17 ADMISSION DATE: 10012000
20 SRC: 1
22 STA: 01
39 VALUE CODES AMOUNT: 61 8050 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV..DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0023	HH Services	HCGL1	10012000		1285.10	
0550	Skilled Nurse	G0154	10012000		95.79	
0571	HH Aide	G0156	10012000		43.37	
0550	Skilled Nurse	G0154	10102000		95.79	
0571	HH Aide	G0156	10102000		43.37	
0550	Skilled Nurse	G0154	10202000		95.79	
0023	HH Services	HCHM1	10252000		2656.28	
0550	Skilled Nurse	G0154	10252000		95.79	
0550	Skilled Nurse	G0154	10302000		95.79	
0550	Skilled Nurse	G0154	11052000		95.79	
0550	Skilled Nurse	G0154	11102000		95.79	
0001					757.27	

50 PAYER: Medicare
51 PROVIDER NO.: 167999
52 REL INFO: Y
DUE FROM PATIENT
58 INSURED'S NAME: Doe, Jane M
60 CERT.-SSN-HIC.-ID NO.: 123456789A
63 TREATMENT AUTHORIZATION CODES: OASIS Matching Key
67 PRIN DIAG CD: 1629
82 ATTENDING PHYS. ID: A12345 Greene, Mark
85 PROVIDER REPRESENTATIVE: X Ima Clerk
86 DATE: 10162000

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

OUTLIER ADJUSTMENTS

Outlier Payments

- **Made in Addition to HHPPS Episode Payments**
- **Limited to 5 Percent of Total Estimated HHPPS Episode Payments**

The HH PPS Pricer will calculate outlier payments on a per-episode basis. Outlier payments are made in addition to the regular case-mix adjusted episode payments for episodes that incur unusually large costs. The final rule requires HCFA to estimate outlier payments based on 5 percent of total HHPPS episode payments during the fiscal year.

As a result, the fixed dollar loss amount and the loss-sharing proportion are chosen so that total outlier payments are estimated to be no more than 5% of estimated total payments. There is no need for a long-stay outlier payment since there is no limitation on the number of continuous episode payments in a fiscal year for a beneficiary. Outlier payments will be made for:

Outlier Payments are Made for All Episodes Where the Estimated Cost Exceed A Computed Outlier Threshold Amount

- Episodes whose estimated cost exceeds the computed threshold amount for the HHRG(s).

  Costs will be estimated for each episode by applying standard per-visit amounts to the number of visits by discipline reported on claims.

- For episode payments that reflect a PEP adjustment or SCIC adjustment. The PEP adjustment results in a truncated episode period and a SCIC adjustment results in a total of the proportional payments under different HHRGs over a 60-day episode, but these periods could still incur unusually large costs.

Outlier Payments are Made for All Episodes Except for LUPAs

- Outlier calculations are not performed for episodes paid on a LUPA basis

Outlier Threshold Equals Episode Payment Plus Fixed Dollar Loss Amount

Fixed Dollar Loss Amount Determined by Applying Fixed Dollar Percentage (113 percent) to Wage Adjusted Standard PPS Amount

The outlier threshold for each claim is defined as the 60-day episode payment for the HHRG(s) plus a fixed dollar loss amount that is the same for all case-mix groups. The fixed dollar loss amount is determined by applying a fixed dollar loss percentage (113 percent) to the wage adjusted standard average prospective payment amount of $2,115.30. The fixed dollar loss percentage has been determined on the basis that outlier payments will be no more than 5% of estimated total HHPPS payments. The outlier threshold for the PEP adjustment is the PEP adjusted episode payment plus the fixed dollar loss. The outlier threshold for the SCIC adjustment equals the SCIC adjusted episode payment plus a fixed dollar loss.

Outlier Payments are Calculated in the following Manner:

1. **Compute Estimated Cost using National Per-Visit Amounts**
2. **Compare to Sum of Per-Episode Payment Plus Outlier Threshold Amount**
3. **Apply Loss Sharing Ratio (.80) to Wage Adjusted Difference**

The outlier payment is defined to be a proportion of the wage adjusted estimated costs beyond the wage-adjusted threshold. The threshold amount is the sum of the wage and case-mix adjusted PPS episode amount and the wage-adjusted fixed dollar loss amount. The proportion of additional costs paid as outlier payments is referred to as the loss-sharing ratio. The loss-sharing ratio is currently .80. The loss-sharing ratio has been determined on the basis that outlier payments will be no more than 5% of estimated total HHPPS payments.

Outlier payments are determined in the following manner:

- Calculate the case-mix adjusted episode payment
- Determine the fixed dollar loss amount by applying the fixed dollar percentage of 113 percent to the standard average prospective payment amount of $2,115.30.
- The case-mix adjusted episode payment plus the fixed dollar loss amount equals the outlier threshold amount
- Calculate imputed cost for the episode based on the national average per-visit amounts. The

national average per-visit amounts for outlier calculations in FY-2001 are listed below:

Home Health Discipline Type	HH Payment Rate
Home Health Aide Services	$43.37
Medical Social Services	$153.55
Occupational Therapy Services	$105.44
Physical Therapy Services	$104.74
Skilled Nursing Services	$95.79
Speech Pathology Services	$113.81

- If the imputed cost exceed the outlier threshold the imputed cost is wage adjusted and the outlier payment is calculated as 80 percent of the amount by which the wage-adjusted imputed costs exceed the outlier threshold. The outlier payment is added to the episode payment.

Sample Outlier Computation (Note: All Calculations are Performed Automatically by the HHPPS Pricer Program)

To assist in understanding the outlier payment concept, we will work through a computation for a sample provider. Required data includes:

- HIPPS Code - HCGL1
- Weight is 1.9532
- Visits by Discipline
  Skilled Nursing – 55 visits
  Home Health Aide – 40 visits
- Wage Index - .9139
- National Average Per-Visit Amounts
  Home Health Aide – $43.37
  Skilled Nursing - $95.79

Note: The national standardized per-visit amounts are multiplied by the number of visits of that discipline

appearing on the provider's claim at the end of the episode.

Step 1 - Calculate Total Imputed Visit Cost

1. Skilled Nursing Visits 55 times $95.79	$5,268.45
2. Home Heath Aide Visits 40 times $43.37	$1,734.80
3. Total imputed Cost (line 1 plus 2)	$7,003.25

Step 2 - Calculate Outlier Threshold Amount

4. Calculate Case-Mix adjusted Episode Amount: Standard PPS Per-Episode Amount $2,115.30 multiplied by HIPPS weight 1.9532 equals $4,131.60	$4,131.60
5. Calculate Fixed Dollar Loss Amount: Standard PPS Per-Episode Amount $2,115.30 times Fixed Dollar Loss Percentage **1.13** equals $2,390.29	$2,390.29
6. Outlier Threshold Amount (line 4 plus 5)	$6,521.89

Step 3 - Calculate Outlier Payment

7. Determine Outlier Amount: Total Imputed Cost (from **Step 1**) $7,003.25 minus Outlier Threshold Amount (from **Step 2)** $6,521.89 = $481.36	$481.36
8. Wage Adjust Labor Portion of Outlier Amount: Multiply Outlier Amount of $481.36 times labor percentage .77668 = $373.86 multiply times wage index .9139 = $341.67	$341.67
9. Determine Non-Labor Portion of Outlier Amount: Outlier Amount of $481.36 minus labor portion of $373.86 equals $107.50	$107.50
10. Wage Adjusted Outlier Amount (line 8 plus 9)	$449.17
11. Outlier Payment equals $449.17 multiplied by 80%	$359.34

Total Payment to Provider (Episode plus Outlier Payment)

12. Wage Adjusted Payment for Episode (from wage adjustment example)	$3,855.31
13. Outlier Payment from line 11	$359.34
14. Total Payment to Provider (line 12 plus 13)	$4,214.65

HH PPS PRICER DESIGN (AS OF 5/16/00)

New Pricer will be Used for HH PPS Services Provided On or After Oct. 1, 2000

Input Data File

The input record layout has been included in the Appendix. The file will be 450 bytes in length.

The claims processing systems will pass the following data from the claim record to the HH Pricer program.

HHA-NPI	Provider Identifier (future claim item)
HHA-HIC	Health Insurance Claim Number
HHA-PROV-NO	Six-Digit OSCAR Provider Number
HHA-TOB	Three-Digit Type of Bill Code
HHA-SERV-FROM-DATE	From Date of Claim
HHA-SERV-THRU-DATE	Through Date of Claim
HHA-ADMIT-DATE	Admission Date of Claim
HHA-HRG-INPUT-CODE	Up to 6 Instances.* First 6 HRGs (HIPPS Codes) That Appear On the Claim

The following data will be calculated by the claims processing systems from the claim and passed to Pricer:

HHA-HRG-NO-OF-DAYS	Up to 6 instances.* The number of days of service applied to each HRG (span of days between the first service date and the last service date under each HRG)
HHA-MED-REVIEW-INDICATOR	Up to 6 instances. A Y/N indicator. An instance of this indicator will correspond with each HRG passed to Pricer. A Y indicator will be passed if the panel code field shows a HIPPS code and the line item pricing indicator on the claim shows the HIPPS code

	was changed in MR. A N indicator will be passed in all other cases. Both FISS and APASS will pass the medical review indicator to Pricer.
HHA-INIT-PYMNT-INDICATOR	A one-position indicator to show the percentage payment to made on initial claims to a specific provider. This value will be set by the intermediary in field 19 (Federal PPS Blend Indicator) of the provider specific file and copied by the Standard System into the Pricer input record. Valid values for 10/2000 will be: 0 = make normal initial payment 1 = pay 0%. Additional values may be added in subsequent years of HH PPS, to allow variable rates of payment.
HHA-REVENUE-DATA	Always six instances, representing each of the six HH disciplines. (H-HHA-REV-CODE will show rev. codes 42x, 43x, 44x, 55x, 56x, and 57x in all cases. The revenue codes must be passed sorted in ascending order.) A count of occurrences for each revenue code will be passed as HHA-COVERED-VISITS-QTY. If no occurrences, pass zeroes. Both FISS and APASS will sort and pass revenue codes (and the quantities for each code) in ascending order to Pricer.
HHA-PEP-INDICATOR	A Y/N indicator. A Y indicator will be passed if the patient status on the claim indicates a transfer (patient status 06) or a discharge w/goals met and return to the same agency (new patient status 06). A N indicator will be passed in all other cases.

	Both FISS and APASS will pass the PEP indicator to Pricer.
HHA-PEP-DAYS	The total number of days in a PEP episode period, calculated from the earliest line item date of service on the claim through the latest line item date of service. In typical PEPs, this number will match the HRG-NO-OF-DAYS. But in cases of SCICs within PEPs, the counts must be distinct. Note: If the HHA-PEP Indicator is set to N the Pricer will default to 60 days even if the range of billable days of service is less than 60 days

- Pricer will only be able to price claims with 6 or fewer HRGs.

RHHIs Will Establish a Medical Policy Parameter to Suspend Claims with More than 6 Lines with Revenue Code 0023 for Medical Review

- RHHIs will establish a Medical Policy Parameter to suspend claims with more than 6 lines with revenue code 0023 for Medical Review. A special workaround process will be developed for the rare case where the seventh change is justified.

- In the course of a future annual update, HCFA may require 15-minute increments, rather than visits, to be counted. In that case, a number calculated from the units field would replace the number of occurrences of the revenue code.

In The Future HCFA May Require 15-Minute Increments, Rather Than Visits to be Counted for Therapy Threshold Calculation

The Appendix includes a copy of the HH Pricer specifications. The specifications describe the Pricer calculations in detail.

PROVIDER SPECIFIC FILE

Fiscal Intermediaries are required to submit provider specific file data for HHAs to HCFA on a quarterly basis. Currently, Section 3850 of MIM Part 3 states the following:

Section 3850 of the MIM Must Be Revised to Require Intermediaries to Maintain Field 19 In Addition to Other Currently Required HHA Provider Specific File Elements.

Hospice and HHA. --Create a provider specific history file using the following data elements for each hospice or HHA. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for these provider types.

Field 19 will be used to identify situations where medical review has determined that no RAPs should be paid to a specific provider. The following one-digit indicator will be used to pay or suppress RAP interim payments:

- O = make normal initial payment.
- 1 = make zero percent payment.

Note: Additional indicators may be added by HCFA to identify different levels of payment.

HH PPS REMITTANCE ADVICE INSTRUCTIONS

Program Memorandum A-00-23, dated April 2000, which contained the outpatient PPS (OPPS) instructions, also included a number of changes that apply to HH PPS.

HCFA Will Not Make Changes to the Following Items for HH PPS:

- **Standard Paper Remittance Advice Format,**
- **ERA 835 Version 3051.4A.01 Implementation Guide, or**
- **PC-Print**.

HCFA will not make changes to the following items for HH PPS:

- Standard paper remittance advice format,
- ERA 835 version 3051.4A.01 implementation guide, or
- PC-Print.

All the statements below on home health billing apply only to type of bills 32X and 33X.

- As with OPPS, detailed service line level data will only be reported in 3051.4A.01 and later versions of the 835. Detailed service line data will not be reported in paper remittance advice notices, or in pre-3051.4A.01 versions of the 835 supported by FISS or APASS.

  The standard paper remittance advice and the FISS version 3051.3A and 3030M 835 transactions will continue to report claim level summary data. Home health providers on FISS who wish to receive service line level data must upgrade to version 3051.4A.01 of the 835.

Home Health Providers on FISS Who Wish to Receive Service Line Level Data Must Upgrade to Version 3051.4A.01 of the 835

- As a general rule, the amount of the first payment for a 60-day episode will be reversed and withheld from the full payment made for the episode at the end of the 60 days.

- Payments for four or fewer visits will be paid using standard per visit rates, rather than under the HH PPS methodology.

- DME is not included in home health PPS payments and must be reported in a separate line/loop for the second bill in an episode. DME may not be included in the first bill for an episode. Separate payments will continue to be made for DME under the DME fee schedule.

- **Separate Payments Will Continue to be Made For DME Under the DME Fee Schedule**

- **Separate Payments Will Continue to be Made for Osteoporosis Drug, Flu Injection, and PPV on 34x-Type Bills.**

- Separate payments will continue to be made for osteoporosis drug, flu injection, and PPV on 34X-type bills.

Intermediary Instructions for 835 Version 3051.4A.01 - Line Level Reporting Requirements for the First Bill/Payment in an Episode.

1. Enter HC (HCPCS revenue code qualifier) in 2-070-SVC01-01, and the Health Insurance PPS (HIPPS) code under which payment is being issued in 2-070-SSVC01-02. The HIPPS code is being treated as a type of level 3 HCPCS in this version.

2. Enter 0 (zero) in 2-070-SVC02 for the HIPPS billed amount and the amount you are paying in SVC03.

3. Enter 0023 (home health revenue code) in SVC04.

4. Enter the number of covered days, as calculated by the standard system for the HIPPS, in SVC05, the covered units of service.

5. If the HIPPS has been down coded or otherwise changed during adjudication, enter the billed HIPPS in 2-070-SVC06-02 with qualifier HC in 2-070-SVC06-01.

6. Enter the start of service date (claim from date) in 2-080-DTM for the 60-day episode. If a revenue code other than 0023 is billed, report the line item date associated with that revenue code instead of the claim from date.

7. Enter group code OA (Other Adjustment), reason code 94 (processed in excess of charges), and the difference between the billed and paid amounts for the service in 2-090-CAS. Report the difference as a negative amount.

8. Enter 1S (ambulatory patient group qualifier) in 2-100.A-REF01 and the HIPPS code in 2-100.A-REF02.

9. Enter RB (rate code number qualifier) in 2-100.B-REF01 and the percentage code (0, 50, 60) in 2-100.B-REF02.

10. 2-110-AMT (ASC, APC or HIPPS priced amount or per diem amount, conditional) does not apply, and should not be reported for either the first or the final remittance advice for a HIPPS episode.

11. 2-120-QTY does not apply to a first bill/payment in an episode. This data element is used for home health payment only when payment is based on the number of visits (when 4 or fewer visits) rather than on the HIPPS.

12. Enter the appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments. There are no appeal rights for initial episode payments.

Intermediary Instructions for 835 Version 3051.4A.01 - Line Level Reporting Requirements for the Second Bill/Payment in an Episode (More than 4 Visits)

Intermediary Instructions for 835 Version 3051.4A.01 - Line Level Reporting Requirements for the Second Bill/Payment in an Episode (More than 4 Visits)

1. Reverse the initial payment for the episode. Repeat the data from the first bill in steps 1-7 in section A, but change the group code to CR and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.

2. Enter CW (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.

3. The full payment for the episode can now be reported for the end of episode bill.

a. Repeat steps A1-11 for the service as a reprocessed bill. Report this data in a separate claim loop in the same remittance

advice. Up to six HIPPS may be reported on the second bill for an episode.

b. In addition to the HIPPS code service loop, also enter the actual individual HCPCS for the services furnished. Include a separate loop for each service. HCPCS are not required to be billed with revenue code 270 services and must be reported in a separate SVC loop in the remittance advice.

c. Report payment for the service line with the HIPPS in the HCPCS data element at the 100 percent rate (or the zero-rate if denying the service) in step 9.

d. Report group code CO, reason code 97 (Payment included in the allowance for another service/procedure), and zero payment for each of the individual HCPCSs in the 2-070-SVC segments. Payment for these individual services is included in that HIPPS payment. Do not report any allowed amount in 2-110.A-AMT for these lines. Do not report a payment percentage in the loops for HCPCS included in HIPPS payment(s).

e. Enter the appropriate appeal messages in a remark code data element in 2-1035-MOA and any appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments.

f. If DME is paid, report in a separate loop(s), and enter the allowed amount for the DME in 2-110.A-AMT.

4. If Pricer determines that a cost outlier is payable for the claim, enter ZZ (outlier amount) in 2-062-AMT01 and the amount of the outlier in AMT02. NOTE: Since this is a claim level segment, this must also be reported in 835 versions 3030M and 3051.3A.

5. If insufficient funds are due the provider to satisfy the withholding created in B step 2, carry the

outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

Intermediary Instructions for 835 Version 3051.4A.01 - Line Level Reporting Requirements for the Second Bill/Payment in an Episode (4 or fewer Visits)

Intermediary Instructions for 835 Version 3051.4A.01 - Line Level Reporting Requirements for the Second Bill/Payment in an Episode (4 or fewer Visits)

1. Reverse the initial payment for the episode. Repeat the data from the first bill in steps 1-7 in section A, but change the group code to CR and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.

Enter CW (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.

2. Now that the first payment has been reversed, pay and report the claim on a per visit basis rather than on a prospective basis. Enter HC in 2-070-SVC01-01, the HCPCS for the visit(s) in 2-070-SVC01-02, submitted charge in SVC02, the paid amount in SVC03, appropriate revenue code (other than 0023) in SVC04, the number of visits paid in SVC05, the billed HCPCS if different than the paid HCPCS in SVC06, and the billed number of visits if different from the paid number of visits in SVC07.

3. Report the applicable service dates and any adjustments in the DTM and CAS segments.

4. The 2-100-REF segments do not apply to per visit payments.

5. Enter B6 in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.

6. Report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.

7. Enter the appropriate appeal messages in a remark code data element in 2-1035-MOA and any appropriate line level remark codes in 2-130-LQ.

8. If insufficient funds are due the provider to satisfy the withholding created in B step 2, carry the outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

Cost Report Impact

- **Cost Reports Still Required**
- **No Separate Cost Reports for Periods Over 10/1/2000**
- **Additional HH PPS Payment Data**
- **Data to be Maintained in Accordance with Provider Reimbursement Manual**

COST REPORT IMPACT

Cost reports will still be required after the implementation of HH PPS. Separate cost reports cannot be filed for services before 10/1/2000 and services on or after 10/1/2000, where the HHA's fiscal year straddles 10/1/2000. HHAs will file a full 12-month cost report regardless of their specific cost reporting year. The Medicare statistics contained in the cost report will be separated for the 10/1/2000 implementation date. Medicare statistics for services before 10/1/2000, will be cost reimbursed, subject to the per-visit and per-beneficiary limitations. Medicare statistics for services on or after 10/1/2000 will be separately accumulated on the cost report.

While revised cost reports have not been issued, it is anticipated that HH PPS number of episodes and payment amounts will be reported on the cost report in the following categories:

- Full episodes without outliers
- Full episodes with outliers
- LUPA episodes
- PEP Episodes

- SCIC Episodes
- Total Episodes

In addition, statistics relating to charges and visits will be accumulated by discipline, as well as non-routine medical supply charges.

HH PPS data will be reported in the PS&R reports provided by the fiscal intermediaries.

Subsequent to the implementation of HH PPS, cost reports will continue to be filed in accordance with HCFA Publication 15-II. The information reported must conform to the requirements and principles set forth in HCFA Publication 15-I. Where a provider fails to file a timely cost report, all interim payments since the beginning of the cost reporting period can be deemed overpayments. (HCFA Publication 15-I, Section 2413)

OTHER HHA SERVICES

Payment under Outpatient Prospective Payment System (OPPS) for Certain Services Provided by HHAs

Certain services will be paid under OPPS for services provided in a HHA. These services relate to vaccines, splints, casts and antigens provided by Home Health Agencies to individuals not under an HHA plan of treatment, within the scope of the home health benefit.

Vaccines, antigens, splints, and casts are billed on bill type 34X using the list of HCPCS codes in the following chart.

Category	**Code**
Antigens	95144-95149,95165, 95170, 95180, 95199
Vaccines	90657- 90659, 90732, 90744, 90746, 90748, G0008, G0009, G0010

Splints	29105- 29131, 29505 – 29515
Casts	29000 –29085,29305,29450,29700 – 29750, 29799

Payment Under the Prospective Payment System for Outpatient Rehabilitation Services

Section 4541 of the BBA required payment under a prospective payment system for outpatient therapy services provided by HHAs to individuals who are not homebound or otherwise are not receiving services under a home health plan of treatment. Effective for claims with dates of service on or after January 1, 1999, the Medicare physician fee schedule will be used as the payment system.

PS&R REPORTS

- **All Existing PS&R Reports Will Continue to be Produced After Implementation of HH PPS.**
- **It Will be Necessary to Cut Off PS&R Reports For Services Provided On Or After Oct. 1, 2000**

All existing PS&R reports will continue to be produced after implementation of HH PPS. However, it will be necessary to cut off PS&R reports for services provided on or after Oct. 1, 2000. The cut-off will be necessary for all providers that have cost reporting periods that straddle Oct. 1, 2000. The cut-off will be required to properly settle cost reports with services subject to IPS

NEW PS&R REPORTS

Several new PS&R reports (or tables) will be added to the PS&R system. The new reports will capture data applicable to HH PPS. At this point, the new reports will be used primarily for HCFA statistical analysis and data collection. However, future changes to the cost report may require use of the reports for completion of the cost report. The following seven new reports will be added for HH PPS:

The following seven new reports (tables) will be added for HH PPS:

1. **PS&R TOTAL EPISODES**
2. **. HHRG TOTALS:**
3. **FULL HHRG EPISODES NO OUTLIERS**
4. **FULL HHRG LUPA EPISODES**
5. **FULL HHRG PEP EPISODES**
6. **FULL HHRG SCIC EPISODES**
7. **FULL HHRG OUTLIER EPISODES**

1. PS&R TOTAL EPISODES

This PS&R report's totals are a summarization of all types of episodes regardless of how they were paid (i.e., full episode, LUPA, SCIC, PEP, Outlier). The field, # of "Up-Coding" HHRG Discrepancy Episodes, is a count of the episodes where the provider's RAP indicates that one of the 40 payment codes which indicates the estimated of the number of therapies has reached the threshold for higher payment, and the final claim does not support that the therapy threshold was reached during the 60-day episode. In such a case, the claim is consequently downgraded to the less costly payment code. The field, # of All Other Adjustment Episodes, is a count of episodes depicting any and all other changes to the claim regarding payment. The field, Total # of Adjustment/Discrepancy Episodes, is a summation of the two previously mentioned discrepancy or adjustment fields. The field Total Non-Routine Medical Supplies includes both non-routine medical supplies currently reported on the cost report, as well as non-routine medical supplies currently unbundled

and billed separately under Part B physician/supplier and outpatient claims.

2. HHRG TOTALS*:*

This PS&R report will show all of the fields listed below for all episodes (collectively) regardless of the payment type (i.e., full episode, LUPA, SCIC, PEP, Outlier).

3. FULL HHRG EPISODES NO OUTLIERS:

This PS&R report will show all of the fields listed below for only episodes paid the full episode payment amount. In other words, episodes paid LUPA, PEP, SCIC, or Outlier, payments are not reflected in this report.

4. FULL HHRG LUPA EPISODES

This PS&R report will show all of the fields listed below for only episodes paid as a LUPA episode.

5. FULL HHRG PEP EPISODES

This PS&R reports will show all of the fields listed below for only episodes paid as a PEP episode.

6. FULL HHRG SCIC EPISODES:

This PS&R report will show all of the fields listed below for only episodes paid as a SCIC episode. There may be some unique ways in which to count the number of episodes and occurrences without over counting for this type of episode.

7. FULL HHRG OUTLIER EPISODES:

This PS&R report shows all of the fields listed below for only episode paid an Outlier payment. This report could reflects all episodes paid as an Outlier payment regardless of how they were paid (i.e. full episode, PEP, or SCIC).

The Field Total # Of Outlier Episodes Will be Reported On All Reports Except for the Following:

- **FULL HHRG EPISODES NO OUTLIERS,**
- **FULL HHRG LUPA EPISODES, and**
- **FULL HHRG OUTLIER EPISODES**

The Field Total Outlier Reimbursements Will Be Reported On All Reports Except For The Following:

- **FULL HHRG EPISODES NO OUTLIERS?, and**
- **FULL HHRG LUPA EPISODES**

Following are the fields that will appear on the new reports:

Total # of Episodes
Total PPS Reimbursements
Total # of Visits
Total Charges
Total # of Aide (health aide) Visits
Total Aide (health aide) Charges
Total # of SN (skilled nursing) Visits
Total SN (skilled nursing) Charges
Total # of PT (physical therapy) Visits
Total PT (physical therapy) Charges
Total # of OT (occupational therapy) Visits
Total OT (occupational therapy) Charges
Total # of SP (speech therapy) Visits
Total SP (speech therapy) Charges
Total # of MS (medical social) Visits
Total MS (medical social) Charges
Total Non-Routine Medical Supply Charges
Of HHRG Up-Coding HHRG Discrepancy Episodes
Of All Other Adjustment Episodes
Total # of Adjustment/Discrepancy Episodes

SAMPLE PS&R REPORTS